MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, December 12, 2002
9:44 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: **Fostering choice in the Medicare program**
-- Scott Harrison, Jill Bernstein

DR. HARRISON: Good morning. When the M+C program was created some policymakers had two goals in mind. One, to offer Medicare beneficiaries a wider choice of private plans. And two, to build a platform for a system of competition among private plans.

The draft chapter we are presenting today looks at these issues. We find that despite declining M+C enrollment over the last few years there are many other choices available to Medicare beneficiaries beyond the traditional fee-for-service and Medicare+Choice programs. We also find that the answer of how competition might work among these plans will depend one a number of issues, including specific national and local market conditions and the circumstances of individual beneficiaries.

Before I get into the chapter I want to give you a quick update on what we've learned about Medicare options for 2003 since the last time we talked. And then I will summarize the three main sections of the March chapter draft, the first being the survey of options available to Medicare beneficiaries, the health insurance marketplace preferences of beneficiaries and plans, and supply and demand factors.

The last time we told you about the PPO demonstration program and promised to give you details about the benefits they will offer when we learned of them. We now have some details and I will give them to you in just a moment. Similarly, we reminded you about the existence of the Medicare HMOs operating under cost contracts and they are higher profile because of a plan transferring some of its members from its M+C plans to its cost contracts. Again we promised to bring you the benefit details and will do so momentarily.

Finally, the administration has proposed regulatory changes to a Medigap program that could have some effect on the supplemental market and I'm going to describe that now. The Medicare Select program began as a demonstration in the early '90s and was made permanent in 1998. Medicare Select policies are Medigap policies that cover more of the cost sharing when beneficiaries use network providers.

From a beneficiaries point of view they are exactly the same as a Medigap policy when they use a network provider but they do not offer as good coverage as a comparable Medigap plan when they use non-network providers. In exchange for giving up some coverage for non-network providers, the Select policies usually have lower premiums than comparable Medigap policies. Insurers are able to offer these less expensive products because providers agree to accept lower than Medicare rates from the insurer in order to participate in the network. Because Medicare continues to pay its share on the claims from Select members, the reductions are really in the form of the provider waiving all or part of its beneficiary cost sharing.

Current Medicare regulations, however, has limited these

cost sharing reductions to hospitals. The IG had ruled that Part B providers could not waive cost sharing without being in violation of anti-kickback rules. Studies of the Select program found that the program was limited because plans could not include physicians in their networks which kept them from any real possibility of saving money through managing care.

The IG has now proposed regs that would allow physicians and suppliers to waive Part B cost sharing if they participate in a network. If physicians are willing to accept lower total Medicare payments to participate, then insurers might be able to pass along savings in the form of lower premiums. Network creation may also allow plans to pursue managed care objectives within their networks. In any event if the regulatory change allows insurers to lower premiums on Select plans they may become a stronger option for beneficiaries.

Let me take a quick look at the 2003 benefit and premium information for the plans designed to replace the Medicare fee-for-service benefit package. Starting with the Medicare+Choice coordinated care plans, here CCPs, almost 60 percent of beneficiaries have a CCP available in their county. This is down from over 70 percent a few years ago. Almost 30 percent of Medicare beneficiaries have a CCP available in their county that charges no premium. That percentage is down from over 60 percent four years ago. But now, due to a provision in BIPA, about 4 percent of beneficiaries will have access to a plan that will in effect pay them to join. The actual transaction is a partial or full rebate on the Part B premium which all Medicare beneficiaries, traditional or Medicare+Choice, must pay in order to be eligible to receive the Part B benefits.

That's why the minus $58.70 on the table refers to a full rebate of the Part B premium. So that's the lowest premium that's charged by M+C plans.

The top of the premium range shows that some plans charge in excess of $200 per month. Of course premiums that high reflects that the plan is providing benefits in addition to the basic Medicare benefits.

As we've talked before, plans in the M+C program are not allowed to have cost sharing, which includes both premium and cost sharing on basic care benefits. That total cost sharing for the basic can't exceed the national average cost sharing of $102 per month. Of course, they can charge more in order to cover the extra benefits in the package.

Almost half of Medicare beneficiaries have an M+C CCP available that covers some prescription drugs. That is also down from four years ago when about 65 percent of beneficiaries had such a plan available. The drug coverage that is offered has also been declining in generosity and some plans may offer generic coverage and that may only come with a monthly limit.

In addition to the drug coverage, we have started to examine a couple of other supplemental benefits that plans might offer, whether they cover all of cost sharing for inpatient hospital services and whether they cover all of the cost sharing for physician services.

We found that almost 30 percent of beneficiaries have a plan

available that does not charge any cost sharing for inpatient hospital services. Total physician cost sharing was a little rarer with only 10 percent having a plan available.

Let's move a little quicker through the other types of plans. For 2003 the private fee-for-service plan -- there's really only one -- will charge a monthly premium of $88. The plan does not cover outpatient drugs. For inpatient hospital services the beneficiary has a copayment of $100 per day up to a maximum of $500 per stay. The beneficiary must notify the plan before a planned admission, otherwise there's an extra charge. For physician services, the beneficiary has a copayment of $15 for each primary care visit and $30 for each specialist visit.

For cost plans premiums range up to $326 per month. Half of the cost plan offerings have monthly premiums between $72 and $116. Less than half of the low option plans include coverage for outpatient prescription drugs. Most of the ones that do not provide coverage do offer higher options choices that do include drug coverage.

Most of the plans charge no cost sharing for inpatient and hospital services in a plan hospital and about one-third do not charge cost sharing for visits to plan physicians.

On the PPO demos, all of the PPO demonstration plans charge premiums ranging from $32 to $184 per month. All but one of the PPOs will offer some coverage for outpatient prescription drugs and about one-fifth of those beneficiaries who have a plan available will have one available that charges no cost sharing for inpatient hospital services. However, total physician coverage is quite rare.

Apart from being able to choose from among these insurance products intended to replace and sometimes supplement the fee-for-service benefit package, beneficiaries can choose from among packages that are designed to supplement the basic package. All aged beneficiaries have the choice to buy a Medigap plan when they first enroll in Medicare. Many beneficiaries also have the choice of buying a Medicare Select plan. Some beneficiaries may also be fortunate enough to have the choice to participate in an employer-sponsored retiree plan. Other beneficiaries may be eligible to receive supplemental benefits from state Medicaid programs and other programs designed to assist low income individuals.

At least when reviewed at the national level, the health insurance market for Medicare beneficiaries offers a number of choices. However there is tremendous variation in availability depending on, for example, each beneficiaries geographic location, work history and income.

It's also important to note that the available choices involve tradeoffs for beneficiaries. The dimensions of choice that are immediately apparent are affordability, flexibility and the scope of benefits. Beneficiaries may not be able to afford some of the health insurance coverage that are available to them, especially options with the broadest scope of benefits. Beneficiaries' choices among coverage options are, however. not only constrained by the availability of the plans described above but also by factors such as underwriting restrictions on Medigap

policies for some beneficiaries, financial resources, and incentives or requirements for participation in employer-sponsored supplemental programs.

Beneficiary preferences in health care needs may also affect the extent to which beneficiaries are interested in considering options or willing to change from one plan to another. So given the choices and limitations, the pie chart here illustrates what insurance beneficiaries carry.

What insurance do beneficiaries want? Judging from surveys and research surveys, we find that for the most part beneficiaries in both fee-for-service and Medicare plan alternatives are quite satisfied with their current health insurance.

Data from the MCBS and the recent data from the Consumer Assessment of Health Plan Surveys or CAHPS show that the ratings of plans and ratings of Medicare, in general, are high. This is consistent with a lot of other survey data that show that most people rate health care well most of the time.

There are a few variations worth noting. People with more serious problems give somewhat lower ratings to both fee-for-service and Medicare+Choice, but those in Medicare+Choice report more or more serious problems. There are variations in satisfaction with M+C plans across regions. They tend to be rated higher in the Northeast and lower in the Pacific and Northwest regions.

Beneficiaries and advocate organizations have expressed a variety of frustrations with the existing systems of choices overall. The research suggests that beneficiaries want to be able to count on their plans being there over time and that they're upset by changes in plan benefits. Being able to stay with their own doctor and being able to choose providers is important to them. Beneficiaries find it very difficult to sort out what M+C plan offerings really are and what they will have to pay out-of-pocket. Finally, they are frustrated by what they see as an unfair system where beneficiaries in some areas get richer benefits for lower premiums than they may be able to get.

What do plans want to participate? Plans believe that the M+C payments have not kept up with the cost of providing care in recent years. They also believe that Medicare regulations and reporting requirements are excessive and burdensome. Plans want to be able to compete with Medicare fee-for-service and other plan models on a level playing field. For example, federal law requires community rating and prohibits underwriting for Medicare+Choice plans but Medigap insurers can underwrite in most states. Plans also want more ability to create more varied products that can meet beneficiaries varied needs.

Clearly beneficiary and plan perspectives do not always align perfectly. Beneficiary advocates are concerned about instability and complexity. They point to the major problems that plagued the supplemental insurance market before plans were standardized in the OBRA '90 reforms. Product variations could also lead to bias selection, adverse selection in insurance products. Consumer protection and education may depend on some regulation and oversight.

To understand what Medicare can and should do to manage these tensions we need to look more closely at how markets are working now.

First, let's look at what CMS has been doing to address these tensions? They have been working hard. They have provided regulatory relief, particularly in marketing and data reporting requirements. They've unveiled extensive consumer education plans. They have facilitated plan marketing to employers and to unions. They have the demonstrations, the PPO demonstration, the latest of what they have been doing, although they have done smaller demonstrations. And they've continued work on risk adjustment which they feel is very important in order to make a competitive market.

The supply of alternative options to Medicare fee-for-service depends on several aspects of the marketplace. For HMOs and other network plans, a key question is if they can create networks. If there are monopoly providers in an area or resistance to managed care, they may not able to form networks. This is particularly a problem if payment levels are low relative to Medicare fee-for-service. State regulations such as rating rules, guarantee issue rules, Medicaid and pharmacy assistance program policies may also affect competition in local markets.

On the demand side if, for example, beneficiaries have an option that subsidizes their expenses, such as employer-sponsored wrap-around supplemental insurance or Medicaid, their demand for HMO options may decrease. Affordability is a key determinant. In low income areas, the demand for pricier products may be low. Finally the local insurance culture may affect the personal preferences of beneficiaries. People who are used to being in HMOs may have a higher demand for managed care products. There are also larger scale dynamics at work.

What is offered and at what price is often affected by larger scale phenomenon. The underwriting cycle, for example, influences whether insurers are trying to increase market share or increase margins. We have been in the margin increasing phase for the last couple of years. Premiums have been increasing and insurers have been withdrawing from less profitable markets.

For network plans there has been a desire by enrollees for larger and more inclusive networks with less utilization review and the response has carried over into the M+C market as well. Finally, providers have consolidated in some markets and pushed back against the managed care plans demanding higher payments. Again this has spilled over into the managed care market for Medicare as well.

Because these marketplace dynamics are so complex and because the decisions beneficiaries, providers and insurers make take place in local markets, we conclude that we need to study some local markets in depth. We plan to conduct in-depth studies in local markets and report these results back in June.

MR. SMITH: I found this very helpful and very clear. Two thoughts and a question.

We surely shouldn't be surprised that consumers want more stability and better benefits or that providers want more money and more flexibility. I thought we made relatively more of that

than we should have, rather than the next section trying to talk about what's happening in the marketplace itself.

My question is every time we talk about what's happened to the shape of or the availability, the distribution of M+C, we also note that the shape of benefits is changing and being more constrained. Do we have any way to size that, to sort of describe anything other than, of course, copays are going up, formularies are being tightened? And maybe it's back to an earlier conversation can we relate that to what's going on with out-of-pocket costs for folks who are finding either their Medigap benefits more constrained or their M+C availability more constrained?

DR. HARRISON: We have sort of the same problem that beneficiaries have, the benefit packages are so complex that it's really hard to quantify everything and figure out how they've changed We can pick a couple of measures and I've picked a couple to try to focus in on but past that it's hard to -- yes, we know that they're less generous but it's hard to quantify it.

The other problem is that we don't know who picks this which option. CMS, I believe, will be starting to report who picks which option within a plan. Like if a plan has a high and low option, we don't know whether they decided to buy the drug coverage or not. We've seen some early results that suggest that they do buy up most of the time but we don't have anything that goes back in time for that data.

MR. SMITH: So taking a beneficiary who made a different choice as her plan changed its options or increased its premiums, we have no way of identifying that. Thanks.

MR. HACKBARTH: Aren't plans required to file statements with the actuarial value of their additional benefits? Can't you track that over time?

DR. HARRISON: They are. We could use the cost reports to get some sense of what the actuarial value they're claiming is.

DR. REISCHAUER: Is that just the free benefits or is this the benefits which they're charging the extra premium for?

DR. HARRISON: They're supposed to do it for all benefits. The problem is that they're usually based on guesses as to what's going to happen as supposed to the past. And since the benefit packages don't stay stable from year-to-year, when they do file past information it's hard to track with that was for.

MS. ROSENBLATT: Just on that last point if you could do some plans with a lot of enrollment and get an actuarial consultant to value -- lets say a given health plan in a given area has three plans, plans one, two and three. And plan one, between 2002 and 2003, you could value it as of 2002 like $100 worth of value and in 2003 it might be $90 worth of value. So you might be able to do it for a sample and that might be a more accurate way of doing it than going back to the cost reports but that's a possibility.

But you won't pick up -- a plan that offers plan one, two, and three with plan three being the richest might stop the just stop offering that plan as opposed to reducing the benefits and you wouldn't pick that up.

I thought this chapter a lot of great stuff in it. I have a

couple of comments. I have a reconciliation issue. Anne's chapter, that we just talked about, made a comment in it that 90 percent of beneficiaries have some form of supplemental coverage. And then this chapter talks about roughly one-third have Medigap, roughly a third have employer-sponsored coverage. And I had a hard time coming up with where's the rest of the 90 percent, even looking at the pie chart you had up there. Some of it's Medicaid but I'm just not getting to 90 percent. So there's something that just doesn't quite gibe.

DR. HARRISON: We have 13 percent in this chart and there is a problem with these numbers. They come from the areas different surveys that don't always match. In fact, we're waiting to update this. We think we'll be getting data next week.

MS. ROSENBLATT: It might be helpful if we get that reconciled, to actually have like a little table where you could break down the 90 percent into its components. Because I don't know if it's just me but when I started reading Medigap is a third -- see I think of Medigap as both individual and employer. And I read the one-third and I went wait a minute, that's impossible. So it might be helpful to have an introduction laying out the components of the 90 percent or whatever that number is and to make sure it agrees with whatever Anne's got in her chapter.

My second comment is on the plan perspective section of this chapter, it really focused on the M+C program and I think there are other things that should be mentioned in the plan perspective. First of all, the comments you made about Medicare Select, that's not yet happened; right?

DR. HARRISON: I think comments were due last month so it has not happened yet.

MS. ROSENBLATT: But I think most plans would be very supportive of that change Medicare Select, so that might be worth mentioning.

And then what was totally ignored would be the plan perspective on Medicare supplement plans. The standard plan issue that I always bring up, which I know beneficiaries get confused, but I always bring up the point that if you can get away from standard plans there's more chance for innovation and experimentation.

And then the unusual kind of comments about rating, underwriting, loss ratios and all that kind of stuff, that I'm not going to get into because Jack will make fun of me if I do.

DR. ROWE: I won't understand it, it's okay.

MS. ROSENBLATT: Also, the consumer satisfaction comments, there was a recent survey -- and I can't remember which research firm did it. It might have been Kaiser on the fact that the minority population was extremely satisfied with M+C. It's Kaiser? And it might be worth including some quotes from there in here.

And then a couple of specific comments. Can explain, you've got something in here about if you assume beneficiaries enroll in PPOs, the value will be 109 percent. It's on page 11, Medicare payments for PPO demonstration plans.

DR. HARRISON: Okay. In the past what I simply did was I

took the rates that would be paid to the PPO plans, took the fee-for-service spending in those counties, and weighted the counties by Medicare eligibles. So if PPOs attracted enrollment in proportion to general Medicare enrollment in the county, then we would end up paying 109 percent of what would be paid under fee-for-service for those people.

MS. ROSENBLATT: Because you're going to get higher weighted --

DR. HARRISON: Because they're higher rate counties.

MS. ROSENBLATT: It's a confusing number, at least it was to me. And I think it could be misinterpreted. So if there some other way of doing that or leaving that out, it just makes it sounds like how do you get from 99 percent to 109 percent?

On page 18, there's a comment, policies for older beneficiaries and attained age-rate policies may cost considerably more than policies that use issue age or community rating. I think that sentence needs a balancing statement that says something like younger beneficiaries benefit from issue ag and community rating just make sure that people understand that it all washes out.

DR. HARRISON: Right, we weren't finished with all the rating stuff.

MS. ROSENBLATT: And then on the employer-sponsored supplement plans, I didn't see anywhere in here that mentioned one of the reasons that employers are cutting back is due to the FASB 106, as well as just increasing costs. And might be worth a mention.

DR. HARRISON: Okay.

DR. NEWHOUSE: I would like to comment on the conclusion and then couple of small points You wound up your talk with we need to understand what happens local markets, and that's kind of the last paragraph of what's in our book. But it comes across much stronger in the talk. And what I'd like o urge you do is actually go on to say not only we to understand what happens but what we would do with it as policy. What I see it points toward is the geographic adjustments in M+C because other than that, in the traditional program architecture it's very hard to do anything about local markets. We have wage adjustment and that's about it, and then we have some kind of rifle shots in certain legislation but that's not really what you're talking about.

But we do have that policy of trying to reduce geographic variation on the M+C side and nothing on the traditional side, which we've certainly banged on that drum before. But it seems to me that's where this points.

What I would urge you to do is not just say we need to understand it but what we would do with that once we understand it, assuming we are capable of understanding it.

So maybe that can be a longer discussion there at the end.

My two nits are right away on page one you say policymakers are concerned that Medicare beneficiaries don't have the same choices of health care delivery systems that workers have. It's my belief that only about half of workers have any choice of health care plans at the place of employment. So I wasn't sure exactly what you meant by that because obviously in traditional

Medicare I can pretty much choose my provider. And we've given as a percentage of the number of beneficiaries that have choice of an M+C plan in addition to traditional. So I wasn't sure that that's factually correct.

DR. HARRISON: I think this was really supposed to point to the PPOs, that fact that workers have a choice of getting at a PPO.

DR. NEWHOUSE: They may not have a choice of a PPO. That's my point.

And then my other thing, and this was really something I didn't quite understand, was on page 22 you talked about more than one million new enrollees in the last five years in the VA, citing a Washington Post article. What does it mean to be enrolled in the VA? I thought you just showed up you were entitled or you didn't show up as your spirits moved to you, you didn't enroll.

DR. HARRISON: I think that's right.

DR. NEWHOUSE: Okay.

MS. DeParle: I just wanted to understand a little bit better the information you provided us about premiums and benefits for 2003. And in particular, do you any more details about the coordinated care plans that are offering the minus $58.70? No premium, basically? How many of them are there? Where are they? How many beneficiaries have access?

DR. HARRISON: They're in Florida. There are some plans in New York who are offering $20 or $30 rebates but Florida is the only place where you can get the full rebate.

MS. DeParle: And they're not offering additional benefits then, it's just a bare bones plan? Or are they offering additional benefits, too?

DR. HARRISON: I looked at those plan and I believe they all offer higher options and so beneficiaries would definitely be trading off cash for better benefits.

MS. DeParle: So they have a higher option plan, as well as the one that's no premium at all?

DR. HARRISON: Right, as I recall, they were pretty bare bones but I think that they did offer some supplementation.

MS. DeParle: Are they all over Florida or are they only in Miami?

DR. HARRISON: Miami and, I believe, Hillsborough County.

MR. FEEZOR: Just a follow-up on Alice's comment. If you reference the private sectors sort of retrenchment due to FASB, you may want to sort of give a heads up on the forthcoming GASB ruling on it, it might prompt similar response from public agencies.

And I think Joe's comments were that if you look at what really happened, a lot of large employers really never bought into the full managed competition theory and hence, did not offer a wide variety. And those that did have even further retrenched in the last few years to drop back in terms of the offering of plans. They've gotten rid of the Aetna's and the Cigna's and so forth. I just wanted to see if Jack was listening.

We've struggled with the issue of choice within my organization. And I guess I wonder if -- and I'm not trying to

expand your horizon here a lot, but the attitude of really how important is choice and whether we want to do some sort of survey our opinion citing here.

When we looked behind it, we have clearly caused a lot of angst among our members because we have dropped from our twelve plan offerings down to four. They said were losing choice. Well, the reality is they had one basic benefit design. When we do survey of our members their choice is, in fact, first and foremost, a choice of provider. And even in our plan elimination, we still have maintained the 90 to 92 percent physician match in each of those moves.

When you scratch a little further in the opinion that it is -- the choice I want is first in my provider, that's more of a freedom of as opposed to a lot of, I think.

And then the second really is it's not so much I want a choice of plans but somehow -- I think maybe Alice touched on it -- there's been this sort of dilution of value. And somehow I'm limited and I would like more value for the same amount of money, which may not be an economic reality. I mean the choice isn't there for that. And so when you really scratch away choice, to some degree, goes away as being a big issue except for the vendors and for the researchers.

MS. DeParle: But we may think that choice as some value from an economic perspective. We believe in markets and --

MR. FEEZOR: That's what I'm saying, let's be clear about why we are pursuing it, why it is important.

MS. DeParle: This isn't a competitive pricing methodology right now but if it ever were presumably one would think there's a value to having more than one participant bidding.

MR. FEEZOR: I couldn't agree more, but I think -- well...

The final thing is that, I guess I was struck by some in there you talk about the fact that when all is said and done, this is a market that either out of ignorance or a lack of choice seems relatively happy with their coverage and in fact are rather static. They don't move a lot. You make that comment in here.

I guess I just wanted for us to focusing in on why we are pursuing choice. I think it may not be saving money. It is sort of the freedom that we sort of think that everybody wants it and we sort of flame that and when you scratch it, you really look below that, it may not the choice as we have thought of it in this model.

MS. WAKEFIELD: Scott, in your list of federal programs that provide coverage to retirees, what would the reason be that IHS wouldn't be listed there? Is there not any interface between IHS and Medicare? Or is there and it was just not listed for some other reason? Where you're listing Medicaid and DOD, et cetera.

DR. HARRISON: I think there is I mean, I think you can be eligible for both. I don't know.

MS. WAKEFIELD: If there is, and this is a chapter that's going to be included, could we just try and get a little bit of language in there about what that might be? Thanks.

DR. ROWE: Scott, just a couple of small things, really matters of emphasis. I think this is very well done.

From the point of view of the health plans, or at least one

health plan, this is really much more about Medigap Reform than it is Medicare reform or change. You mention, under the section on health plans, you have an introductory sentence that says something about that, that health plans would like to see a level playing field where they could compete for Medigap programs.

But then you go in and all the rest is all about M+C changes and other kinds of changes within Medicare, as opposed to Medigap changes. And I think that it might be helpful to have a little more balance with respect to that, or throw in some of the other discussion about changes in the Medigap program or possibility of offering different kinds of programs.

The president, I think, came up with the suggestion of two additional Medigap plans, didn't he, President Bush a year or so ago? I don't know what happened to that, but he was going add K and L, wasn't he, at one point?

DR. HARRISON: Last year.

DR. ROWE: There might be some discussion about that and trying to get people more access, that was one approach to getting people access to outpatient prescription drugs, et cetera.

I just think if you lined up a bunch of health plan executives there's more interest in trying to compete in the Medigap and make those products more attractive and more responsive to people's needs.

The second thing has to do at the PPO, which I think is misnamed. And you pointed out to us in the past that there were really two things going on here. One is it's a PPO rather than a more restricted network with access et cetera, and that's easier. But the other is they waive the cap.

So there are really are two experiments at once. Is the traction that it gets related to waiving the cap, or is it related to the network and certification issues? And I think that you mention that toward the end of the chapter, you that in a paragraph. But I think that that deserves to be seen with a little more sunshine on that because I think that that is, in fact, a pathway, independent of the network issues that might be something for CMS to consider. That would be something that would open things up a little bit.

So a little more emphasis on that. Unless you're among the cognoscenti or you're really reading this very carefully, you're going to miss that, sort of the second of three points that you make, the kind of inside baseball points about the PPO demonstration. And I think it might benefit from a little more emphasis. That certainly was part of what attracted us to it.

DR. REISCHAUER: Can I ask you how you'd like us to describe this, that this demonstration allows the plans to increase the costs on sick Medicare beneficiaries?

DR. ROWE: No, you could do that if you want and I would actually --.

DR. REISCHAUER: That is the description you want.

DR. ROWE: I would leave that up to the media, actually, which I think generally you're not a member of, but not always.

I guess what I was say is it provides Medicare beneficiaries with the choice of paying more for a broader set of benefits than

they -- or different kind of structure than they would get in traditional Medicare. It's all about this is not mandatory, this is all voluntary. And it's about there are Medicare beneficiaries out there who instead of buying Medigap, might be more attracted to these other policies. That would be an alternative proposal.

But thank you very much for you suggestion.

MS. DeParle: On that point, do we have any data yet on how many folks have enrolled in the PPO demos?

DR. HARRISON: Enrollment opens January 1st, so we won't -- if we were really lucky we might know by the end of January who signed up in January, at least, but I don't know how reliable that would be.

MS. BURKE: I know this isn't really the focus of this chapter, which I think was quite well done, there is a discussion on Medicaid that is contained in the section that discusses sort of other alternatives, along with the VA and some other things. You're left wondering at the end of the comment what it is that's not working because of the large number of individuals who are eligible who do not choose to participate.

There is also, following that one paragraph, a discussion under the heading Medicare beneficiaries that sort of raised some of the issues that you raised about the program, about some of the choices.

I think there is, in fact, something to be learned and, I think, some greater understanding of some of the challenges that are faced in terms of Medicaid because it is a safety net and, in fact, participates -- I mean, there's 17 percent of the population that are involved as it is, which is not an insignificant number. The fact that there are more 20 percent actually eligible choose not to, I think, might bear at least some additional explanation.

You reference a particular study that notes the fact that people choose not to. There are lots of reasons that we've speculated on over the years as to why and I think we might at least add a small amount -- again, this is not the focus of this chapter, but I think it might enlighten folks in terms of looking at what some of these very low income beneficiaries confront in terms of their choices and sort of the limitations and what Medicaid offers or doesn't offer.

DR. REISCHAUER: Scott, I just thought, on the first page you should not make it sound like the first introduction of the choice of HMOs came about with the Balanced Budget Act of '97 but there was a program, the TEFRA thing, before.

MR. HACKBARTH: Scott, could you give us a quite update on the status of the risk adjustment system and implementation of it?

DR. HARRISON: I haven't heard much. I know Dan has been talking a little more with people.

DR. ZABINSKI: We don't know. Basically I think they just started collecting the data or are soon to collect the data. So we really don't know a heck of a lot at this stage.

MR. HACKBARTH: My recollection was that January was when they actually start to file data reports with CMS?

DR. HARRISON: I believe they have started collecting -- I haven't had confirmation of that. I think actually it's October. But the dates I do know, in February there's going to be a public meeting where I believe they well -- CMS will discuss, I think they will discuss the final model. And then towards the end of March they actually have to put in the Federal Register the 45-day announcement on what their method will be for setting rates for 2004 and in that they will have to lay out the final model.

MR. HACKBARTH: Another question, Scott. Could you tell me how the rates paid by the private fee-for-service plan -- the rates paid to providers, compare with Medicare rates for providers?

DR. HARRISON: It's the same. If you were to apply to CMS to offer private fee-for-service product, you'd have to guarantee a network of providers who take your rates. The way this latest plan did it was they simply said we'll pay Medicare rates, which should guarantee participation.

MR. HACKBARTH: If they're paying Medicare rates to providers and they're in floor counties which, by definition, increase the payment to the private plan above Medicare fee-for-service costs, remind me what happens to the increment, the difference? There should be money left over.

DR. HARRISON: I know they file either one or two cost reports for their entire service area. So they're not doing stuff county by county. And they're projecting total costs over their area, and they do offer something in the way of supplemental benefits. Some of the copays are lower.

DR. REISCHAUER: But they're also charging a premium.

DR. HARRISON: They're also a premium. Right now enrollment is over 20,000. It's been growing steadily but that's what they've gotten to so far.

MR. HACKBARTH: One last question. This goes back to something Jack said. The issue of the level playing field, as it were, between M+C plans and Medigap plans, this is something, as you look at local markets and their dynamics, this is something that you will explore for the June report; is that right?

DR. HARRISON: Yes, it's going to be very complicated and I really think you'd need to do it market by market because the Medigap rates vary like crazy, the M+C availability varies quite a bit. So in order to sort this stuff out and see how the competition really lays out, I think you really have to get into local markets.

MR. HACKBARTH: Any other questions or comments on this chapter? Okay, thank you.